

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-006450

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 220

FILED FEB 26 1962

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Green</u>				a. STATE <u>Mo</u> b. COUNTY <u>Christian</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield, Mo</u>				Length of stay in 1b <u>30 Min</u>		c. CITY OR TOWN <u>Highlandville</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St John Hospital</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>South Galloway Twsp</u>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>VERNON</u> Middle <u>CARLSON</u> Last <u>CARLSON</u>				Month <u>Feb</u> , Day <u>17</u> , Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>I/17/62</u>	
9. AGE (last birthday) <u>66</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Holdridge, Neb</u>	
13a. FATHER'S NAME <u>Victor Carlson</u>				13b. MOTHER'S MAIDEN NAME <u>Laura Anderson</u>		14. NAME OF HUSBAND OR WIFE <u>Agnes H Carlson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				17. INFORMANT <u>Mrs Agnes H Carlson, Mo</u>		Address: <u>Highlandville,</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Medullary Paralysis</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage</u>							
DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <u>8/27/58</u> Month, Day, Year <u>2/17/62</u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>8/27/58</u> to <u>2/17/62</u> and last saw him alive on <u>2/17/62</u> Death occurred at <u>2/17/62 7:P.M</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Doctor or file) <u>Wm. P. McCreich</u>				22b. ADDRESS <u>Ozark Mo</u>		22c. DATE SIGNED <u>2/18/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/22/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prairie Home,</u>		23d. LOCATION (City, town, or county) (State) <u>Holdridge, Nebraska</u>	
24. FUNERAL DIRECTOR <u>F. W. Chaffin</u>				ADDRESS <u>Ozark, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>2-19-62</u>	
26. REGISTRAR'S SIGNATURE <u>Effie E. Minton</u>							

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

OCT 24 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed T. B. Chabbin

Licensed Embalmer No. 2192

P. O. Address Ozark, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.